Utah Specific Transaction Instructions

837 Health Care Claim: Dental
ASCX12N 837 (004010X097A1)

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for healthcare as established by the Secretary of Health and Human Services. The ANSI ASC X12N 837D Version 4010 implementation guide has been established as the standard of compliance. Utah Medicaid will implement the Addenda corrections for the Health Care Claims: Dental (004010X097A1). The implementation guide is available electronically at www.wpc-edi.com. The following supplemental requirements are specific to Utah Medicaid and are intended to serve as a companion guide to the HIPAA ANSI X12N implementation guide. For clarification regarding submission of encounter records, refer to the encounter provider manual. Further billing instructions and policy are published in the Utah Medicaid Provider Manual.

Requirements:

1. An Electronic Commerce Agreement must be in place. The form is available at www.UHIN.com.

2. A Utah Medicaid EDI Enrollment form must be completed and on file prior to the submission of eligibility inquiries. The form is available at www.health.utah.gov/hipaa/medicaid. Transactions submitted without an Electronic Transmitter Identification Number (ETIN) or Trading Partner Number (TPN) on file with Medicaid will be rejected back to the sender.

3. 837 claims may be sent anytime 24 hours a day, 7 days a week. Transactions sent after noon on Friday will not be included in the following week remittance.

4. Utah Medicaid recommends submitting 18 or fewer service lines for each Dental claim. Claims submitted with more than 18 service lines will be split and may be subject to processing delays

5. A 997 Functional Acknowledgment will be created for all 837 transactions.

6. A 277 Health Care Claim Status Notification - Front End Acknowledgment will be created for all 837 transactions.

7. All references to Medicaid are used for simplicity, but other programs supported by Health Care Financing (HCF) are also included, e.g., Non-Traditional Medicaid, Primary Care Network, IHC Access, Baby Your Baby, etc.

Page	Loop	Segment	Data Element	Values / Comments
56		BHT06	Claim or Encounter Indentifier	“CH”
61	1000A	NM109	Submitter Identifier	Trading partner number
67	1000B	NM103	Receiver Name	“Utah Medicaid FFS”
67	1000B	NM109	Receiver Primary Identifier	“HT000004-001"
84	2010AA	REF01	Reference Identification Qualifier	“1D”
84	2010AA	REF02	Billing Provider Additional Identifier	Use the 12 digit identifier assigned by Utah Medicaid.
87	2010AB	NM1	Pay-to-Provider	Medicaid’s claims processing utilizes billing provider information.
97	2000B	HL04	Hierarchical Child Code	“0" - Subscriber is always the patient, there are no dependents in Utah Medicaid.
101	2000B	SBR09	Claim Filing Indicator Code	“MC”
104	2010BA	NM102	Entity Type Qualifier	“1"
105	2010BA	NM108	Identification Code Qualifier	“MI”

Page	Loop	Segment	Data Element	Values / Comments
106	2010BA	NM109	Subscriber Primary Identifier	Use the 10 digit identifier assigned by Utah Medicaid. Do not submit hyphens or spaces.
118	2010BB	NM103	Payer Name	“Utah Medicaid FFS”
118	2010BB	NM109	Payer Identifier	“HT000004-001"
132	2000C	HL	Patient Level	The subscriber is always the patient in Utah Medicaid. It is not necessary to complete this loop.
151	2300	CLM05-3	Claim Frequency Code	Medicaid will allow for submission of electronic corrections and voids to a previously paid claim. Code “6" or “7" in this data sub-element will be treated as a “replacement” for the original claim.
153	2300	CLM11	Accident/ Employment Related Causes	Use appropriate code to indicate type of accident.
155	2300	CLM19	Predetermination of Benefits Code	Utah Medicaid will not process a predetermination of benefits request.
171	2300	PWK01	Attachment Report Type Code	Required if documentation is needed to support the claim. Claims may deny, however once documentation is received the claim will be reprocessed.
171	2300	PWK02	Attachment Transmission Code	“BM”, “EM” or “FX”

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172	2300	PWK06	Attachment Control Number	Must be unique with each claim and each attachment associated to the claim. Attachment control number must be submitted on attachment.
180	2300	REF02	Claim Original Reference Number	When codes “6", “7" or “8" are submitted in 2300 CLM05-3, the Transaction Control Number (TCN) assigned to the original claim must be reported.
182	2300	REF01	Reference Identification Qualifier	“G1" for prior authorizations. Utah Medicaid does not utilize referral numbers.
182	2300	REF02	Prior Authorization or Referral Number	Use the 7 digit prior authorization number assigned by Utah Medicaid.
209	2320	SBR	Other Subscriber Information	If the patient has Medicare or other coverage, repeat this loop for each other payer. Do not put information about Utah Medicaid coverage/ payment in this loop.
216	2320	CAS02	Adjustment Reason Code	Output adjustment codes as reported by other payer.
216	2320	CAS03	Adjustment Amount	Report amount relating to adjustment reason code.
220	2320	AMT02	Payer Paid Amount	Report amount received from other payer.
222	2320	AMT02	Allowed Amount	Report allowed amount as reported by other payer.

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223	2320	AMT02	Other Payer Patient Responsibility Amount	Report amount as reported by other payer.
246	2330B	DTP03	Adjudication or Payment Date	Report date claim paid by other payer.
248	2330B	REF02	Other Payer Secondary Identifier	Use qualifier “F8” and output the other payer claim number if known.
265	2400	LX	Line Counter	Utah Medicaid recommends submitting 18 or fewer service lines for each Dental claim. Claims submitted with more than 18 service lines will be split and may be subject to processing delays.
267	2400	SV301-3 to SV301-6	Procedure Modifier	Utah Medicaid will not utilize modifiers for dental claims processing.
268	2400	SV304	Oral Cavity Designation	Report quadrant and arch associated with procedure requiring data.
270	2400	SV306	Procedure Count	Report number of times procedure is performed. Multiple units (quantity) are limited to x-ray procedure codes.
272	2400	TOO02	Tooth Number	Report tooth number associated with procedure requiring data.
272	2400	TOO03	Tooth Surface	Report tooth surface associated with procedure requiring data.

Page	Loop	Segment	Data Element	Values / Comments
288	2400	NTE01	Note Reference Code	“ADD”
288	2400	NTE02	Claim Note Text	Provide description of services rendered when utilizing a not otherwise classified procedure code.